Medi-Cal DRG Project

Frequently Asked Questions

Please note that changes remain possible before the implementation date.

Changes have been made since the April 13, 2012 version was published on the DHCS website.

OVERVIEW QUESTIONS

1. What is the Medi-Cal DRG project?

As directed by the California legislature, the Department of Health Care Services (DHCS) is developing a new method of paying for hospital inpatient services in the fee-for-service Medi-Cal program. This FAQ document is intended to provide interested parties with periodic updates on the project. Please note that no decisions have been finalized about how the new payment method will work.

2. How are hospitals currently paid?

Since 1983, hospitals have been paid under the Selective Provider Contracting Program (SPCP). "Contracted" hospitals negotiate a per diem payment rate with the California Medical Assistance Commission. Non-contracted hospitals are reimbursed based on interim rates using a cost-to-charge ratio and subject to a cost settlement process. (Note: designated public hospitals have a separate payment method).

3. What change is being made?

The California Legislature directed the department to replace the current reimbursement methodology for hospital acute care inpatient services (both negotiated contract rates and non-contract cost reimbursement) with payment by Diagnosis Related Group (DRG). The reference is to Senate Bill 853, passed in October 2010, which added Section 14105.28 to the California Welfare and Institutions Code.

4. What is the timeframe?

A workgroup of staff from DHCS and other state agencies is developing the new method, in consultation with a group of hospital managers and other stakeholders convened by the California Hospital Association (CHA). The workgroup finished its work in February 2012. The original target date to implement payment by DRG was July 1, 2012; it is now January 1, 2013.

5. Will there be a transition period?

Yes. The DRG-based payment method will be phased in over a three year period with the changes fully implemented in the fourth year, similar to what Medicare does with major payment changes. Claims will be paid using the DRG payment method but some hospitals will see DRG base prices higher or lower than they otherwise would have been. The transition plan limits first year changes to approximately 5%. The intention of the transition period is that individual hospitals will not experience sharp changes (either up or down) in payment levels. The transitional DRG base prices will be set so that statewide payments are budget-neutral relative to what they otherwise would have been.

Annual base prices will be provided to each California hospital for the transition period. We plan to provide the year 1 individual hospital base rate and estimates of the years 2-4 base rates by late summer 2012. The plan is to modify rates annually. However, because of assumptions such as those made for

documentation and coding improvement, as well as the need to remain budget neutral with overall payment, midyear adjustments could be made. Prospective changes are preferred, but retrospective is an option to ensure budget neutrality.

6. How much money will be affected?

In FY 2009, approximately $4.5 billion was paid to hospitals for fee-for-service inpatient acute care. Of that, approximately $1 billion was paid to designated public hospitals that are outside the scope of the DRG payment method. Another significant portion—estimated at $800 million—was paid for services to beneficiaries who likely will be enrolled in managed care by 2013. Total payments in 2013 to be made by DRG will depend on the total number of people in Medi-Cal fee-for-service during that year and on legislative appropriations.

7. What providers will be affected?

The new method will apply to general acute care hospitals, including out-of-state hospitals and hospitals designated by Medicare as critical access hospitals. Psychiatric hospitals, alcohol and drug rehabilitation facilities, and designated public hospitals are outside the scope of the change to a DRG based payment system. These facilities will continue to be paid as they are today. With regard to rehabilitation hospitals and services, please see Question 10.

8. What services will be affected?

For affected hospitals, the new DRG method will apply to all inpatient hospital fee-for-service claims except the following, for which the current payment method will continue to be in effect:

- Psychiatric stays, regardless of whether they are in a distinct-part unit or not
- Rehabilitation stays (see Question 10)
- Managed care stays (see Question 11)
- Administrative days (see Question 43)
- Other services as may be determined by DHCS

9. Will DRGs affect CCS and GHPP patients?

Claims for clients who have coverage under the California Children's Services (CCS) or Genetically Handicapped Person Program (GHPP) will be priced using the new DRG method. This is true for all CCS or GHPP clients regardless of whether they also have Medi-Cal coverage or only coverage under CCS or GHPP (no Medi-Cal coverage).

10. What impact will there be on rehabilitation care?

Rehabilitation services—either within a general hospital or a specialty rehabilitation facility—are currently paid under the SPCP, that is, at a negotiated hospital-specific per diem rate or, for noncontract hospitals, at 100% of allowable cost. At this time, we do not expect rehabilitation services to be paid by DRG. Instead, the recommendation is to pay for rehabilitation services at a statewide per diem rate, with all days subject to the treatment authorization request (TAR) process. Rehabilitation stays would be identified by the presence of a rehabilitation revenue code on the claim.

11. Will the change affect payments by Medi-Cal managed care plans?

The statutory language about DRG payment applies only to fee-for-service Medi-Cal. Managed care plans may or may not choose to adopt the DRG payment method in whole or in part. When managed care beneficiaries receive emergency care from out-of-network hospitals, the managed care plan currently pays the hospital the "Rogers Rate," which reflects fee-for-service rates calculated under the SPCP. These rates under SPCP have been confidential and are being discontinued due to the transition to DRG payment. Under DRG payment, payment methods and rates will be public knowledge, so managed care plans will pay hospitals based on the fee-for-service (FFS) DRG payment method. Please see Question 45 that describes resources for understanding details about the DRG payment method.

12. Will Medicare crossover claims be affected?

Yes. The Department's current policy of comparative pricing—in which the Medicare allowed amount is compared with what the Medi-Cal allowed amount would have been—will be continued. The difference will be that the Medi-Cal allowed amount will be calculated using the DRG payment method rather than per diem.

DRG PAYMENT

13. How do DRG payment methods work?

In general, every complete inpatient stay is assigned to a single diagnosis related group using a computerized algorithm that takes into account the patient's diagnoses, age, major procedures performed, and discharge status. Each DRG has a relative weight that reflects the typical hospital resources needed to care for a patient in that DRG, relative to the hospital resources needed to take care of the average patient. For example, if a DRG has a relative weight of 0.50 then that patient is expected to be about half as expensive as the average patient.

The DRG relative weight is multiplied by a DRG base price to arrive at the DRG base payment. For example, if the DRG relative weight is 0.50 and the DRG base price is $8,000 then the payment rate for that DRG is $4,000.

14. Who uses DRG payment?

The Medicare program implemented payment by DRG on October 1, 1983. About two-thirds of state Medicaid programs use DRGs, as do many commercial payers and various other countries. Many hospitals in the U.S. use DRGs for internal management purposes.

15. What are the characteristics of DRG payment?

- DRG payment defines "the product of a hospital," thereby enabling greater understanding of the services being provided and purchased.

- Because payment does not depend on hospital-specific costs or charges, this method rewards hospitals for improving efficiency.

- Because DRGs for sicker patients have higher payment rates, this method encourages access to care across the full range of patient conditions.

- DRG payment rewards hospitals that provide complete and detailed diagnosis and procedure codes on claims, thereby giving payers and policymakers better information about services provided.

16. What other payment policies are typically included in DRG payment methods?

For over 90% of stays, it is likely that payment will be made using a "straight DRG" calculation—that is, payment equals the DRG relative weight times the DRG base price, as described in Question 13. In special situations, payment may also include other adjustments, for example:

- *Transfer pricing adjustment*. Payment may be reduced when the patient is transferred to another acute care hospital.

- *Cost outlier adjustment*. Medicare and other DRG payers typically make additional "outlier" payments on stays that are exceptionally expensive for a hospital. Some payers also have a payment reduction if a stay is exceptionally profitable for a hospital. Nationally, outlier adjustments typically affect 1% to 2% of all stays and a higher percentage of all DRG payments.

- *Partial eligibility*. In some situations, a patient may have Medi-Cal eligibility for only part of the stay. In these situations, the hospital would be paid the full DRG amount if the coverage period

was at least as long as the average length of stay (ALOS) for that DRG. If the coverage period was shorter than the ALOS, then payment would be cut back.

- *Other health coverage and patient cost-sharing*. The calculations described above determine the allowed amount. From the allowed amount, payers typically deduct payments from other health coverage (e.g., workers' compensation) as well the patient's share of cost. No changes are planned to current Medi-Cal policies or procedures on other health coverage or share of cost.

17. How will the DRG be assigned?

DHCS plans to use All Patient Refined Diagnosis Related Groups (APR-DRGs) version 29. See the next question for further information.

18. Where do the DRG relative weights come from?

DHCS plans to use APR-DRG relative weights calculated from the Nationwide Inpatient Sample. An analysis found very close correlation between the national weights and a set of weights calculated specifically from Medi-Cal fee-for-service data. The national weights are updated annually by 3M Health Information Systems.

19. What will be the DRG base price?

This question remains under discussion. Medi-Cal will use wage areas to adjust the hospital-specific base price, in much the same way as Medicare does. In addition, in order to facilitate access to beneficiaries living in remote rural areas it is expected that there will be higher base prices for these hospitals (the definition of remote rural hospital is available in the PDD, please see question 45).

20. How will transfers be paid?

We expect that Medi-Cal will follow the Medicare model for transfers to another acute care hospital. For these stays, the transferring hospital would be paid the lesser of:

- The DRG base payment

- A per diem amount times the actual length of stay plus one day (to recognize the up-front costs of admission). The per diem amount would be the DRG base payment divided by the DRG-specific average length of stay.

The effect would be to reduce the DRG base payment if the actual length of stay at the transferring hospital is less than overall average length of stay minus one day. The receiving hospital would receive the full DRG payment. Medi-Cal would define a transfer as UB-04 discharge status values 02, 05, 65 and 66. The tentative recommendation is that Medi-Cal, unlike Medicare, would not have a post-acute transfer policy.

21. How would the hospital indicate a situation of partial eligibility?

- If the patient gains fee-for-service Medi-Cal eligibility during the stay, then the hospital should bill occurrence code A2 (effective date for Medi-Cal coverage).

- If the patient loses fee-for-service Medi-Cal eligibility during the stay, then the hospital should bill occurrence code A3 (benefits exhausted). Because the beneficiary was still an inpatient on the last date of coverage, the claim would show discharge status 30, but the presence of occurrence

code A3 will lead the claims processing system to treat the claim as a complete stay for payment purposes.

In these situations, the hospital will either receive full DRG payment or the DRG payment will be prorated, depending on whether the beneficiary's eligible days were more or less than the average length of stay for the DRG.

22. How will interim claims be paid?

Interim claims will be accepted for stays that exceed 30 days. In these situations, the hospital will be paid a per diem amount (still to be determined). When the patient is discharged, the earlier claims should be adjusted or voided and a single, admit-through-discharge claim submitted. Final payment will then be calculated by the DRG method. Payment of interim claims is unusual among DRG payers but is being put in place to help ensure access to care for sick newborns and other patients with unusually lengthy stays.

23. How is payment made for the most expensive patients?

DHCS is considering recommendations for a two tiered outlier policy and a two tiered NICU policy adjustor to provide additional payment for the most costly patients. Please see the PDD for more information; see question 45.

24. How have decisions been made about the new payment method?

A baseline dataset was created using actual data from DHCS extracted from the CA-MMIS Medi-Cal claims payment system. This data was matched to Office of Statewide Health, Planning and Development (OSHPD) data to increase the number of diagnosis and procedure codes available for DRG pricing. 2009 paid claims were selected by discharge date, interim claims were chained together, and many other claim validation and improvement techniques were used to create a baseline dataset for analysis. DRGs were assigned to the dataset using V.29 of the 3M APR-DRG software. This dataset has been used to simulate results by applying policy adjustors, age adjustors, outlier limits, etc. Using this process, DHCS is able to model the impact of policy decisions on claims data overall and by hospital. These results were shared within the CHA consultation group.

ALL PATIENT REFINED DRGs

25. Why were APR-DRGs chosen? Why not the same DRG algorithm as Medicare uses?

APR-DRGs were chosen because they are suitable for use with a Medicaid population, especially with regard to neonatal, pediatric and obstetric care, and because they incorporate sophisticated clinical logic to capture the differences in comorbidities and complications that can significantly affect hospital resource use.

MS-DRGs—the algorithm now used by Medicare—were designed for a Medicare population using only Medicare claims. In Medicare, fewer than 1% of stays are for obstetrics, pediatrics, and newborn care. In the Medi-Cal fee-for-service population, these categories represent about two-thirds of all stays.

26. Who developed APR-DRGs? Who uses them?

APR-DRGs were developed by 3M Health Information Systems and the National Association of Children's Hospitals and Related Institutions (NACHRI). According to 3M, APR-DRGs have been licensed by over 20 state and federal agencies and by 1,600 hospitals. APR-DRGs have been used to adjust for risk in analyzing hospital performance; examples are state "report cards" such as www.floridahealthfinder.gov and analysis done by organizations such as the Agency for Healthcare Research and Quality and the Medicare Payment Advisory Commission.

APR-DRGs are also in use or planned for use in calculating payment by the State of Maryland; Medicaid programs in Colorado, Montana, New York, North Dakota, Pennsylvania, Rhode Island, South Carolina, and Texas; and Wellmark, the BlueCross BlueShield plan in Iowa.

27. In order to be paid, would my hospital need to buy APR-DRG software?

No. The Medi-Cal claims processing system will assign the APR-DRG and calculate payment without any need for the hospital to put the DRG on the claim. For hospitals interested in learning more about APR-DRGs, go to www.3m.com/us/healthcare/his/products/coding/refined_drg.html. DHCS and Xerox Government Healthcare Solutions (which is advising the Department) have no financial interest in APR-DRG software or in any business arrangements between hospitals and their vendors who license APR-DRGs.

28. What version of APR-DRGs will be implemented?

The Department intends to implement V.29 of APR-DRGs, which was released October 1, 2011. Version 30 will be released October 1, 2012, but the Department plans to implement V.29 because all policy decisions and impact simulations are being done using V.29. Version 29 will accept all diagnosis and procedure codes effective in 2013.

29. What is the APR-DRG format?

Each stay is assigned first to one of 314 base APR-DRGs. Then, each stay is assigned to one of four levels of severity (minor, moderate, major or extreme) that are specific to the base APR-DRG. Severity depends on the number, nature and interaction of complications and comorbidities. For example, APR-DRG 139-1 is pneumonia, severity 1, while APR-DRG 139-2 is pneumonia, severity 2. Unlike MS-DRGs, there are no universal lists of complications and comorbidities.

For hospitals that choose to acquire APR-DRG software, staff should note that the software outputs the base APR-DRG and the severity of illness as two different fields. Medi-Cal would concatenate these

fields for purposes of calculating payment. The APR-DRG is therefore four bytes (ignoring the hyphen), in contrast to the three-byte MS-DRG field.

CODING AND BILLING

30. Would the hospital have to submit the APR-DRG on the UB-04 paper form or the 837I electronic transaction?

No. DHCS would assign the APR-DRG based on the diagnoses, procedures, patient age, and patient discharge status as submitted by the hospital on the claim. The UB-04 field for "PPS Code" (Form Locator 71) is not read by the Medi-Cal claims processing system. The PPS Code field is used when, for example, the hospital needs to advise a commercial insurer of the DRG for a stay. This situation would not apply to Medi-Cal.

31. How many diagnoses and procedures will be used in DRG assignment? Why is this important?

Currently, the California claims processing system (CA-MMIS) stores two diagnoses and two procedure codes. Enhancements will be made to the system to accept possibly as many as 25 diagnosis codes and 25 procedure codes. Hospitals should bill all diagnoses and procedures related to a hospital stay to ensure that the appropriate DRG and patient severity of illness (SOI) are assigned. This will ensure accurate capture of patient acuity. Each DRG and SOI has an assigned relative weight. This relative weight directly effects payment. (Relative weights are published as a separate worksheet in the DRG calculator. Please see question 45.)

32. How will ICD-10 affect the DRG payment method?

When ICD-10 is implemented nationwide, the Medi-Cal claims processing system will accept ICD-10 diagnosis and procedure codes and crosswalk them to ICD-9-CM codes that the system will use for internal processing. This will continue until a replacement claims processing system currently being developed gets implemented. The new claims processing system will utilize ICD-10 codes for internal processing. Independent of the Medi-Cal claims processing system in use, hospitals should follow national guidelines in submitting ICD-10 codes to Medi-Cal. The ICD-10 implementation date has been delayed from October 1, 2013, until October 1, 2014.

33. Will the present-on-admission indicator be used?

Yes. Hospitals should submit valid values of the POA indicator. The claims processing system will be enhanced to accept, edit and store these values, which will be used in identifying health care-acquired conditions (Question 42). For the official guidelines on how to apply the POA indicator as well as information on complete and accurate documentation, code assignment and reporting of diagnoses and procedures, please see the ICD-9-CM Official Guidelines for Coding and Reporting at http://www.cdc.gov/nchs/icd/icd9cm.htm.

34. Will outpatient services related to the inpatient stay be bundled?

In general, there will be no change to the Medi-Cal distinction between outpatient and inpatient services (e.g., when a patient receives outpatient emergency or diagnostic services on the day of admission). One exception is that under the SPCP, a few hospitals can bill for a short list of specialized, high-cost services (e.g., blood factors) on an outpatient claim even when provided on an inpatient basis. Once the new payment system is implemented then all hospitals will be able to bill the following items on an outpatient claim for separate payment.

- Blood Factors
- Bone Marrow search and acquisition costs

35. How does this affect contracted SPCP rates that bundled the physician component of hospital services with the hospital component?

The physician component will become separately billable on a professional (e.g., CMS-1500) claim. This situation only affects a few hospitals that previously had negotiated bundled physician/hospital payments for specific services.

36. Will there be changes in billing requirements?

Some changes in billing requirements are expected, such as those listed below. Hospitals should wait for official notification from DHCS before making any changes in claims submission.

- Separate claims would be submitted for a newborn and a mother. (Currently, there is no separate newborn claim except in specific circumstances.)
- Claims for late charges will not be accepted.
- Interim claims, will only be paid for stays exceeding 30 days, and in increments of at least 30 days thereafter.
- Administrative and rehabilitation days would be submitted on a claim separate from the claim for the acute care stay.

OTHER QUESTIONS

37. What changes, if any, will be made to supplemental payments?

Medi-Cal has several programs under which it makes supplementary payments to hospitals, e.g., for medical education and disproportionate share hospitals. These payments are unaffected by the transition to DRG payment.

38. How will this affect the overall payment level?

The change to DRGs is a change in payment *method*, not payment *level*. The overall payment level will continue to be determined each year through the legislative appropriation process. The statute that required DRG implementation also required that implementation be budget-neutral in aggregate.

39. How will the change affect funding to each hospital?

Because there will be a major change in the payment method, some hospitals will see decreases in payments while other hospitals will see increases. The impacts will depend on decisions that have not yet been made, most importantly whether there are policy-based adjustments to certain care categories and the specific levels of the DRG base price. There will be a transition period of three years; see Question 5. The transition period currently being considered limits the first year impact to an approximate maximum positive or negative change of 5%. Final impact will be determined when base prices are calculated over the three year transition period. DHCS will advise hospitals on the expected impacts of the change, while maintaining the confidentiality of previous hospital-specific payment levels under the SPCP.

40. Will payments be subject to adjustment after cost reports have been submitted?

No, except for limited circumstances, as cost-settlement will no longer occur. The focus of audits will change upon implementation of the new payment system. The Department may audit stays that receive an outlier payment among other items which could be subject to adjustment.

41. Will hospitals still have to submit cost reports?

Yes. The Department will continue to utilize cost reports for a variety of reasons including for calculating hospital utilization fees and in reviewing hospital payments overall.

42. Will there be changes to the Treatment Authorization Request (TAR) Process?

Yes. Simplification of the TAR process is expected to be a major benefit of DRG payment. With the caveat that no final decisions have been made, DHCS is reviewing the following draft recommendations.

- For stays paid by DRG:
    - Continuation of the current TAR requirements on the medical necessity of the admission, including CCS and GHPP admissions. That is, authorization would be required for all admissions except for deliveries and normal newborns.
    - Discontinuation in almost all cases of the current TAR requirement on the length of stay.
    - Discontinuation of the current TAR requirement for days of care related to induction of labor.
    - Continuation of the current TAR requirement for a short list of specific procedures for all beneficiaries.
    - Continuation of the current TAR requirement for procedures for beneficiaries with restricted Medi-Cal eligibility. (In practice, the most common example is a

cholecystectomy for cholecystitis where medical management might be sufficient according to federal guidelines.)

- For stays not paid by DRG:
    - Continuation of current TAR requirements on both the admission and the length of stay for administrative days, hospice, and rehabilitation (see Question 10).
    - Designated Public Hospitals (DPH) will continue their current process.

43. How will payment be affected if a hospital-acquired condition is present on the claim?

Medicaid programs nationwide are required by federal law to demonstrate that they are not paying for "health care-acquired conditions (HCACs)," as defined specifically by CMS. The list is virtually identical to the Medicare hospital-acquired condition (HAC) list that hospitals are already familiar with.

Based on an analysis of data from Medi-Cal, Medicare and other states, we expect payment to be reduced on fewer than 1% of stays. (This figure could change if CMS expands the list of HCACs.)

The Medi-Cal claims processing system would identify HCACs from the diagnosis, procedure and POA information on the claim and disregard the HCAC in assigning the APR-DRG. Payment for the stay would therefore only be affected if the presence of the HCAC would otherwise have pushed the stay into a higher-paying APR-DRG.

44. What impact will there be on administrative days?

Under the existing payment method, administrative days were approved through the TAR process and paid at a statewide per diem. Generally, administrative days are defined as days of service provided to beneficiaries who no longer require acute hospital care, but need nursing home placement or other subacute or post–acute care that is not available at the time. With the transition to a new payment method the Department is considering implementing two levels of administrative days.

Administrative Days – Level 1: These would be days which are paid under the existing system and will continue to be treated the same under the new policy. These days will continue to require a daily TAR and be billed under revenue code 169.

Administrative Days – Level 2: This would be a new level, parallel to Level 1, except at a higher rate for higher acuity patients. Criteria are being developed to distinguish Level 1 care from Level 2. Level 2 days would be billed using revenue code 199 (other subacute care).

45. Where can I go for more information?

- *FAQ.* Updates of this document will be available on the DHCS website at http://www.dhcs.ca.gov.

- *PDD.* The Policy Design Document (PDD) provides more detail on the change in payment methodology to APR-DRG. DHCS plans to publish the PDD on the DHCS website at http://www.dhcs.ca.gov.

- *DRG Grouping Calculator*. 3M Health Information Systems has agreed to provide all California hospitals with access to an APR-DRG Grouping Calculator at no charge. The calculator is a web application that enables the user to enter diagnosis, procedure and other claims data and then shows the step-by-step assignment of the APR-DRG. For the web address and login information, CHA members can go to the "members" section of the CHA website at

http://www.calhospital.org. Hospitals that are not CHA members may contact Jack Ijams at jhijams56@mmm.com.

- *DRG Pricing Calculator*. DHCS plans to publish a DRG Pricing Calculator spreadsheet on the DHCS website at http://www.dhcs.ca.gov. It will not assign the APR-DRG but it will show how a given APR-DRG will be priced in different circumstances. The calculator will include a complete list of APR-DRGs and related information for use in California. We expect it to be posted in the spring of 2012.

- *Hospital training sessions*. Hospital trainings will be held across the state, most likely in the fall of 2012.

- *Hospital provider manual*. The hospital provider manual will be updated to show details of the DRG based payment method.

For Further Information

DRG project management questions
Nathan Davis
Policy Advisor, Health Care Financing
California Department of Health Care Services
Nathan.Davis@dhcs.ca.gov
916-445-0807

Technical questions re DRG payment, relative weights, outlier calculations etc.
Dawn Weimar
Project Director, Payment Method Development
Government Healthcare Solutions
Xerox State Healthcare
dawn.weimar@acs-inc.com
262-365-3592

Hospital consultation process
Amber Ott
Vice President, Finance
California Hospital Association
aott@calhospital.org
916-552-7669